

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)			MEDICAID <input type="checkbox"/> (Medicaid #)			CHAMPUS <input type="checkbox"/> (Sponsor's SSN)			CHAMPVA <input type="checkbox"/> (VA File #)			GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>			FECA BLK LUNG (SSN) <input type="checkbox"/>			OTHER (ID) <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM DD YY M F						4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)																	
CITY						STATE						8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						CITY						STATE											
ZIP CODE						TELEPHONE (Include Area Code) ()						Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>						ZIP CODE						TELEPHONE (INCLUDE AREA CODE) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER												b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F						c. EMPLOYER'S NAME OR SCHOOL NAME						d. INSURANCE PLAN NAME OR PROGRAM NAME											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																							
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)												15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE												17a. I.D. NUMBER OF REFERRING PHYSICIAN						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____												23. PRIOR AUTHORIZATION NUMBER																							
24. A DATE(S) OF SERVICE. From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																																			
1																																			
2																																			
3																																			
4																																			
5																																			
6																																			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>						26. PATIENT'S ACCOUNT NO.						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO						28. \$ TOTAL CHARGE						29. \$ AMOUNT PAID						30. \$ BALANCE DUE					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____												32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____																	